CENTERSTOR	C MEDICARE & MEDIC						B NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDW		00	COMPLETED	
		155359	A. BUILDING	u		02/01/	/2012
			B. WING				-
NAME OF F	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP CODE		
			7519 WINCHESTER RD				
RIVERBE	END HEALTH CAR	E CENTER	FC	ORT W	/AYNE, IN 46819		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)				TE	DATE
F0000	REGUESTION OF	CESC IDENTIFIED IN CREATITION,	171	+			BITTE
1 0000							
	 	4 I	Food	\ \	This Plan of Correction does n	ot	!]
		or the Investigation of	F0000		constitute an admission or	iΟί	
	Complaint IN00	102878.			agreement by the Provider of the		
					truth of the facts alleged or	uie	
	Complaint IN00	102878-Substantiated.			conclusions set forth in this		
		ficiency related to the			Statement of Deficiencies. Th	is	
		•			Plan of Correction is prepared		
		ited at F 223, F225, F			soley because it is required by		
	226.				State and Federal law.Date of		
					Compliance 2/21/12		
	Unrelated defici	encies are cited			·		
		d deficiencies are cited.					
		20 21 2012 1					
	*	nuary 30, 31, 2012 and					
	February 1, 2012	2					
	Facility number:	000250					
	Provider Number						
	AIM Number: 1	00289980					
	C						
	Survey team:	-					
	Ann Armey, RN	1					
	Census bed type	:					
	SNF/NF: 45						
	Total: 45						
	10001.						
	Census payor ty	ne:					
		pc.					
	Medicare: 6						
	Medicaid: 31						
	Other: 8						
	Total: 45						
	10001.						
	G 1						
	Sample: 5						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

VFIP11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/01/2012		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	These deficienci	es reflect state findings nce with 410 IAC !6.2. completed on February 7,					

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Event ID: VFIP11

Facility ID: 000250

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00		COMPLETED	
		155359	B. WIN			02/01/	2012
	PROVIDER OR SUPPLIER		•	7519 W	ADDRESS, CITY, STATE, ZIP CODE VINCHESTER RD WAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		MONITORING BY AN OF CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	L	DATE
F0223 SS=D	verbal, sexual, phy corporal punishme seclusion. The facility must n	he right to be free from ysical, and mental abuse, ent, and involuntary ot use verbal, mental,					
	sexual, or physica punishment, or invalidation based on interviet the facility failed free from physica abuse. This deficing residents with all resident abuse, we reviewed, in a sa (Resident #C and Findings include 1. On 1/30/12 a indicated there he investigation regitive employees here the clinical reconstruction of the residual facility on 6/28/1 included but were dementia and and the manual clinical reconstruction of the manual clini	l abuse, corporal voluntary seclusion. ews and record review, I to ensure residents were al, verbal and mental ciency affected 2 of 3 legation of staff to vhose records were imple of 5. I Resident #D) : t 10:00 a.m., LPN #1 and been an abuse arding Resident #C and and been terminated. rd of Resident #C was 0/12 at 2:00 p.m., and ident was admitted to the 1, with diagnoses which is not limited to, xiety. mum Data Set and short tem memory	F02	23	F223 Abuse and Neglect-Self reports confirmed1. Resident in longer in the facility unable apply corrective actions. Investigation was completed related to alleged aqbuse and neglect facility followed ISDH guidelines for reportable incidence. Resident #C remain the facility.2. Facility completed investigation per IS guidelines. Facility conducted resident interviews to determine there were any other instances abuse. There were no other reports. 3. Staff re-ducated or policy and procedure related to behavior manage ment and change in condition. Interdisiplinary team will conducted resident interview thru use of Guardian Angel weekly to ensualleged abuse of behaviors are acted on appropriately. Administrator or designee will review weekly the facility grievance log for completion of identified concertelated to abuse and behaviors.4. Results of these reviews will be forwared to the facility risk management quality assurance committee for review and recommendations times 2	ns DH ne if s of n C uct ure e c q A	02/21/2012

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Event ID: VFIP11

Facility ID: 000250

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00		LETED
	155359	B. WING		02/01	/2012
		7519 W	/INCHESTER RD	DE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
resident required transfer and exter	limited assistance for nsive assistance for		months for 100% compli-	ance.	
written by LPN # following, At 10:30 p.m., R from bed to bed in CNA (Certified in the was redirected resident was saying don't want you have At 11:15 p.m., a from the nurse prometion of the resident was able as ordered." At 11:30 p.m., "In the CNA was able as ordered." At 1:00 a.m., the bed. The note into an hour to get resistaff et (and) pac (wheelchair) after the control of th	esident #C was going in her room and hit the Nursing Assistant) when ed. The note indicated the ng "This is my house I ere." In order was obtained ractitioner for Ativan 0.5 ramuscularly, as needed, ac (with) assistance from the to inject res (resident) resident was resting in dicated "took a little over a (resident) to quit hitting ing c (with) w/c resident was observed to on her right forearm by 2 cm and 2 cm by 2				
A facility incider	nt reporting form				
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENT REGULATORY OR decisions. The M resident required transfer and exter hygiene and toile On 11/30/11 and written by LPN # following, At 10:30 p.m., R from bed to bed in CNA (Certified N she was redirecter resident was saying don't want you have At 11:15 p.m., a from the nurse pr mg. orally or intrevery six hours. At 11:30 p.m., " the CNA was able as ordered" At 1:00 a.m., the bed. The note income an hour to get resistaff et (and) pac (wheelchair) after On 12/1/11 at 9:3 indicated the resistance was suring 3 cm in cm.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) decisions. The MDS indicated the resident required limited assistance for transfer and extensive assistance for hygiene and toileting. On 11/30/11 and 12/1/11, Nursing notes written by LPN #3 indicated the following, At 10:30 p.m., Resident #C was going from bed to bed in her room and hit the CNA (Certified Nursing Assistant) when she was redirected. The note indicated the resident was saying "This is my house I don't want you here." At 11:15 p.m., an order was obtained from the nurse practitioner for Ativan 0.5 mg. orally or intramuscularly, as needed, every six hours. At 11:30 p.m., " c (with) assistance from the CNA was able to inject res (resident) as ordered" At 1:00 a.m., the resident was resting in bed. The note indicated "took a little over an hour to get res (resident) to quit hitting staff et (and) pacing c (with) w/c (wheelchair) after injection. On 12/1/11 at 9:30 a.m., nursing notes indicated the resident was observed to have two bruises on her right forearm measuring 3 cm by 2 cm and 2 cm by 2	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) decisions. The MDS indicated the resident required limited assistance for transfer and extensive assistance for hygiene and toileting. On 11/30/11 and 12/1/11, Nursing notes written by LPN #3 indicated the following, At 10:30 p.m., Resident #C was going from bed to bed in her room and hit the CNA (Certified Nursing Assistant) when she was redirected. The note indicated the resident was saying "This is my house I don't want you here." At 11:15 p.m., an order was obtained from the nurse practitioner for Ativan 0.5 mg. orally or intramuscularly, as needed, every six hours. 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ROYIDER OR SUPPLIER ROYIDER OR SUPPLIER ROYIDER OR SUPPLIER SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) decisions. The MDS indicated the resident required limited assistance for transfer and extensive assistance for thygiene and toileting. On 11/30/11 and 12/1/11, Nursing notes written by LPN #3 indicated the following, At 10:30 p.m., Resident #C was going from bed to bed in her room and hit the CNA (Certified Nursing Assistant) when she was redirected. The note indicated the resident was saying "This is my house I don't want you here." At 11:30 p.m., an order was obtained from the nurse practitioner for Ativan 0.5 mg. orally or intramuscularly, as needed, every six hours. At 11:30 p.m., " c (with) assistance from the CNA was able to inject res (resident) as ordered." At 1:00 a.m., the resident was resting in bed. The note indicated "took a little over an hour to get res (resident) to quit hitting staff et (and) pacing c (with) w/c (wheelchair) after injection. On 12/1/11 at 9:30 a.m., nursing notes indicated the resident was observed to have two bruises on her right forcarm measuring 3 cm by 2 cm and 2 cm by 2 cm.

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Event ID: VFIP11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012	
	PROVIDER OR SUPPLIEI		7519 W	ADDRESS, CITY, STATE, ZIP CODE /INCHESTER RD //AYNE, IN 46819	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	had been caring night shift, were pending an investigative taken from CNA LPN #3 hit Resi. An investigative from the LPN #4 report, between shift on 11/30/11 and CNA #2 yel statement indicathe resident yell holding her left at the room" An investigative from the acting lemployed by the entering (Reside ask if we may peallegations of about that she did in hight because showith me than (si bruises were not The final incider undated, indicate #2 were terminal monitored for an which currently	e statement, dated 12/1/11, a #2, indicated she saw dent #C. e statement, dated 12/1/11, 4, indicated that, during the evening and night 1, she could hear LPN #3 ling at Resident #C. The ted "At one point I heard 'ouch' and saw her arm when she came out of e statement, dated 12/1/11, DON (No longer facility) indicated "Upon ont #C's name) room to be erform a skin check due to house, the resident stated to not like that nurse last he was mean and argued co) she "hit me"two ed to right forearm"			

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	OF CORRECTION OF CORRECTION 155359	(X2) MULTIPLE CO A. BUILDING B. WING	00	02/01	SURVEY LETED /2012	
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
TAG	The Employee Coaching Plan, for LPN #3, dated 12/7/11, indicated the employee was terminated for verbal and physical abuse. The Employee Coaching Plan, dated 12/7/11, for CNA #2, indicated the employee was terminated for failure to report physical abuse. On 1/30/12 at 5:00 p.m., the Administrator was interviewed and indicated she was not aware of the incident until the morning of 12/1/11. The Administrator indicated LPN #4, who was one of the night nurses, reported the altercation between LPN #2 and Resident #C to the day shift Nurses, on 12/1/11. The Administrator indicated, LPN #3 and CNA #2 were suspended, an investigation was initiated and statements were taken from the individuals involved. She indicated CNA #2 did not report that	TAG		PRIATE	DATE	
	she saw LPN #3 hit the resident until they questioned her. The Administrator indicated two additional nurses (LPN #4 and LPN #5) received disciplinary warnings because they did not immediately intervene when they heard the altercation taking place and because they did not report the altercation immediately to the administrator.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MULTI A. BUILDIN B. WING		nstruction 00	(X3) DATE COMPL 02/01 /	ETED	
	PROVIDER OR SUPPLIER		ST 75	19 WI	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was reviewed on indicated the res facility on 6/18/2 psychiatric hosp readmitted to the with diagnosis w Schizoaffective 2 On 11/14/11 at 4 indicated Reside screaming, throw						
	unsigned, dated #6 was suspende at Resident #D c agitated throwin refusing medicat The statement al came up behind her causing her t An investigative 11/16/11, writter "I began work @ 11-14-2011(C down and hugge	n investigative report, 11/15/11, indicated CNA ed because he made faces rausing her "to become g items in her room and tion" so indicated CNA #6 Resident #D and poked to be startled and agitated. statement, dated h by RN #16 indicated (a) (at) 2:30 p on Monday (b) A #6's name) bent d (Resident #D). ent #D's name) became					
	very upset & (an	nd) irritated. Resident then screaming saying 'keep					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN			02/01/	2012
NAME OF P	PROVIDER OR SUPPLIEF	\ \			DDRESS, CITY, STATE, ZIP CODE		
DIVEDDE		E CENTER			INCHESTER RD VAYNE, IN 46819		
	RIVERBEND HEALTH CARE CENTER			l	VATINE, IIN 40019		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		then heads down the hall		1710			DATE
	· /	The statement further					
		nt #D thought RN #16					
		her medicine and					
		6 was making faces at					
	her.	o ao maning 14000 at					
	The final incide	nt reporting form,					
	undated, indicate						
	·	e alligation (sic) was					
	substantiated and employee immediately terminated,"						
	The Coaching Pl	an, dated 11/17/11,					
		6 was terminated					
	because the emp	loyee caused mental					
	distress to a resid	lent.					
	On 1/31/12 at 10	:05 a.m., the					
	Administrator in	dicated Resident #D					
	reported the alleg	gation of mental abuse to					
	her on 11/15/11	at 11:00 a.m. The					
	Administrator in	dicated the resident told					
		during the evening shift,					
	CNA #6 made fa						
		or indicated the CNA					
	was immediately	suspended and an					
		s conducted. The					
		dicated the investigation					
		#6's behavior had caused					
	the resident men	tal distress.					
	This Federal tag	relates to Complaint					

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Event ID: VFIP11

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012			
	ROVIDER OR SUPPLIER END HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
			(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION PRIATE			

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Event ID: VFIP11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DDIC	00	COMPL	ETED
		155359	A. BUII			02/01/	2012
			B. WIN		ADDRESS STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					INCHESTER RD		
RIVERBE	END HEALTH CARE	E CENTER		FORT	VAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWDERIG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE	DATE
F0225	The facility must n	ot employ individuals who	<u> </u>				
SS=D	have been found of						
		treating residents by a					
		ve had a finding entered					
		se aide registry concerning					
		istreatment of residents or					
	misappropriation of	of their property; and report					
		nas of actions by a court of					
	law against an em	ployee, which would					
		for service as a nurse aide					
	•	iff to the State nurse aide					
	registry or licensin	g authorities.					
	c						
	The facility must ensure that all alleged						
		g mistreatment, neglect, or					
	•	njuries of unknown source					
		ion of resident property are ely to the administrator of					
	the facility and to						
	accordance with S						
		dures (including to the					
		certification agency).					
	otato our roy una c	oorumoduon agonoy).					
	The facility must h	ave evidence that all					
	alleged violations						
	•	must prevent further					
		nile the investigation is in					
	progress.	•					
	The results of all in	nvestigations must be					
	reported to the add						
		entative and to other					
		ance with State law					
		tate survey and certification					
	agency) within 5 working days of the incident,						
	and if the alleged						
ļ		tive action must be taken.		ا م د	L FOOF Demanting 11 11 11	ļ	00/01/0010
		ews and record review,	F0225	:25	F225 Reporting allegations of		02/21/2012
	the facility failed	to ensure staff reported			abuse1. Resident is no longer in the facility unable to apply		
allegations of abuse immediately to		use immediately to the				nn l	
	C	2 of 3 residents with			corrective actions. Investigation was completed related to alleged		
	administrator 101	2 of 3 residents with			was completed related to alleg	c u	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETE	ED
		155359	B. WIN			02/01/201	12
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER			VAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	OMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	allegations of sta	aff to resident abuse in a			aqbuse and neglect facility		
	sample of 5.				followed ISDH guidelines for reportable incidence. Resider		
	(Resident #C and	d Resident #D)			#C remains in the facility.2.	it	
					Facility completed investigatio	n	
	The findings inc	lude:			per ISDH guidelines. Facility		
					conducted resident interviews		
	1. On 1/30/12 at 10:00 a.m., LPN #1				determine if there were any ot		
		ad been an abuse			instances of abuse. There we no other reports. 3. Staff	re	
		arding Resident #C and			re-ducated on policy and		
		and been terminated.			procedure related to behavior		
	two employees n	iad been terminated.			manage ment and change in		
	m 1: : 1	1 05 11 110			condition. Interdisiplinary team		
		ord of Resident #C was			will conduct resident interview		
		0/12 at 2:00 p.m., and			thru use of Guardian Angel		
	indicated the res	ident was admitted to the			weekly to ensure alleged abus of behaviors are acted on	e	
	facility on 6/28/1	11, with diagnoses which			appropriately.Administrator or		
	included but wer	re not limited to,			designee will review weekly th		
	dementia and an	xiety.			facility grievance log for		
					completion of identified conce	rns	
	The MDS (Mini	mum Data Set			related to abuse and		
	,	ted 1/17/12, indicated the			behaviors.4. Results of these reviews will be forwared to the		
		g and short tem memory			facility risk management qualit		
	problems with di	-			assurance committee for revie		
	_	IDS indicated the			and recommendations times 2		
					months for 100% compliance.		
		l limited assistance for					
		nsive assistance for					
	hygiene and toile	eting.					
	On 11/30/11 and	1 12/1/11, Nursing notes					
	written by LPN 7	#3 indicated the					
	following,						
	_	esident #C was going					
	_						
	At 10:30 p.m., R from bed to bed CNA (Certified)	nesident #C was going in her room and hit the Nursing Assistant) when ed. The note indicated the					

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Event ID: VFIP11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155359	B. WIN	G		02/01/	2012
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
			7519 WINCHESTER RD				
RIVERBE	END HEALTH CARI	E CENTER		FORT V	VAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	ing "This is my house I					
	don't want you h						
	_	n order was obtained					
	_	ractitioner for Ativan 0.5					
	mg. orally or into	ramuscularly, as needed,					
	every six hours.						
	At 11:30 p.m., "	c (with) assistance from					
	the CNA was ab	le to inject res (resident)					
	as ordered"						
	At 1:00 a.m., the	resident was resting in					
	bed. The note indicated "took a little over						
	an hour to get re	s (resident) to quit hitting					
	staff et (and) pac	ing c (with) w/c					
	(wheelchair) afte	er injection.					
		-					
	On 12/1/11 at 9:	30 a.m., nursing notes					
	indicated the resi	ident was observed to					
	have two bruises	on her right forearm					
		by 2 cm and 2 cm by 2					
	cm.						
	A facility incide	nt reporting form					
	1	A #2 and LPN #3, who					
		for Resident #C on the					
		suspended on 12/1/11,					
		stigation of allegations of					
	verbal and physic	•					
		statement, dated 12/1/11,					
	_	#2, indicated she saw					
	LPN #3 hit resid	-					
		statement, dated 12/1/11,					
		, indicated that during					
		the evening and night					
		, she could hear LPN #3					
	311111 011 11/30/11	, she could heat Li in #3					

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Event ID: VFIP11

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	OF CORRECTION OF CORRECTION 155359	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	and CNA #2 yelling at Resident #C. The statement indicated "At one point I heard the resident yell 'ouch' and saw her holding her left arm when she came out of the room" An investigative statement, dated 12/1/11, from the acting DON (No longer employed by the facility) indicated "Upon entering (Resident #C's name) room to ask if we may perform a skin check due to allegations of abuse, the resident stated to me that she did not like that nurse last night because she was mean and argued with me than (sic) she "hit me"two bruises were noted to right forearm" The final incident reporting form, undated, indicated both LPN #3 and CNA #2 were terminated. "Resident monitored for any negative outcomes which currently are none. Family and MD notified on 12/1/2011 of alligation (sic) and bruises." The Employee Coaching Plan, for LPN #3, dated 12/7/11, indicated the employee was terminated for verbal and physical abuse. The Employee Coaching Plan, dated 12/7/11, for CNA #2, indicated the employee was terminated for failure to report physical abuse. On 1/30/12 at 5:00 p.m., the			

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Event ID: VFIP11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155359	B. WING		02/01/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	l .
NAME OF F	PROVIDER OR SUPPLIEF	₹		VINCHESTER RD	
RIVERBE	END HEALTH CAR	E CENTER	FORT	WAYNE, IN 46819	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX	`	ICY MUST BE PERCEDED BY FULL			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		as interviewed and			
		s not aware of the			
		e morning of 12/1/11.			
		or indicated LPN #4, who			
	was one of the n	ight nurses, reported the			
	altercation between	een LPN #2 and Resident			
	#C to the day sh	ift Nurses, on 12/1/11.			
	The Administrat	or indicated, LPN #3 and			
	CNA #2 were su	spended, an investigation			
	was initiated and	d statements were taken			
	from the individ	uals involved.			
	She indicated Cl	NA #2 did not report that			
		hit the resident until they			
		Γhe Administrator			
		ditional nurses (LPN #4			
		ceived disciplinary			
	warnings becaus				
		ervene when they heard			
		iking place and because			
		ort the altercation			
		he administrator.			
		ne administrator.			
	2 The aliminal.	nasand af Dasidant #D			
		record of Resident #D			
		1/31/12 at 9:00 a.m., and			
		ident was admitted to the			
	*	10, was transferred to a			
	1 ^ -	ital on $10/1/11$, and was			
		e facility on 10/10/11,			
	with diagnosis w				
	Schizoaffective 1	Disorder.			
		4:50 p.m., nursing notes			
	indicated Reside	ent #D was yelling,			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE COMPL	
1111212111	or conditions	155359		LDING		02/01/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				INCHESTER RD		
RIVERBE	END HEALTH CARE	ECENTER		FORT V	VAYNE, IN 46819		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ving wreath off door and		TAG	DLI ICILICE I		DATE
	_	thair across the hall.					
	tossing a wheel e	man across the nam.					
	A statement in a	n investigative report,					
		11/15/11, indicated CNA					
	#6 was suspende	d because he made faces					
		ausing her "to become					
		g items in her room and					
	refusing medicat						
		so indicated CNA #6					
	_	Resident #D and poked					
	her causing her to	o be startled and agitated.					
	An investigative	statement dated					
		by RN #16 indicated					
	· ·	(at) 2:30 p on Monday					
		NA #6's name) bent					
	down and hugge	d (Resident #D).					
	Resident (Reside	nt #D's name) became					
		d) irritated. Resident then					
		screaming saying 'keep					
	your hands off m	-					
	· · · · · · · · · · · · · · · · · · ·	then heads down the hall					
		ne statement further					
		nt #D thought RN #16					
	was lying about l						
	her.	6 was making faces at					
	1101.						
	The final incide	nt reporting form,					
	undated, indicate						
		e alligation (sic) was					
	substantiated and	l employee immediately					
	terminated,"						

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE /INCHESTER RD WAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	The Coaching Plan, dated 11/17/11, indicated CNA #6 was terminated because the employee caused mental distress to a resident.			
	On 1/31/12 at 10:05 a.m., the Administrator indicated Resident #D reported the allegation of mental abuse to her on 11/15/11 at 11:00 a.m. The Administrator indicated the resident told her on 11/14/11, during the evening shift, CNA #6 made faces at her. The Administrator indicated the CNA was immediately suspended and an investigation was conducted. The Administrator indicated the investigation confirmed CNA #6's behavior had caused the resident mental distress. This Federal tag relates to Complaint IN00102878. 3.1-28(c)			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	JIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155359	B. WIN			02/01/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/INCHESTER RD		
	END HEALTH CARE	ECENTER		FORT V	WAYNE, IN 46819		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
F0226 SS=D	•	evelop and implement d procedures that prohibit					
33-0	mistreatment, neg						
		appropriation of resident					
	property.					Į	
	A. Based on inter	rviews and record	F02	26	F226 Reporting allegations of		02/21/2012
	review, the facili	ty failed to ensure facility			abuse1. Resident is no longer	ın	
	staff followed est	tablished policies			the facility unable to apply corrective actions. Investigation	on l	
	regarding reporti	ng allegations of abuse			was completed related to alleg		
	immediately to th	ne administrator for 2 of			aqbuse and neglect facility		
	3 residents with a	allegations of staff to			followed ISDH guidelines for		
	resident abuse in	a sample of 5.			reportable incidence. Resident #C remains in the facility.All current employee files were		
	(Resident #C and	•					
		,			audited for reference checks.		
	B Based on inter	rviews and record			The administrator or designee		
		lity failed to follow			audit all new employee files for		
		lete reference checks on			completion of reference check This information will be submit		
	-	ninated for abuse and			to QA for review.2. Facility	icu	
		Ference checks in the			completed investigation per IS	DH	
		f five of five employees,			guidelines. Facility conducted		
	-	ly hired. This deficiency			resident interviews to determin		
	affected 6 of eigh	•			there were any other instances abuse. There were no other	3 01	
	_	s #6, #7, #8, #9, #10,			reports. 3. Staff re-ducated or	n	
	#11)	5 #0, #7, #6, #7, #10,			policy and procedure related to)	
	#11)				behavior manage ment and		
	The Carlines in a				change in condition.	ıot	
	The findings incl	lude.			Interdisiplinary team will conduresident interview thru use of	ici	
	A 1 O 1/20/10) at 10.00 a I DNI //1			Guardian Angel weekly to ensi	ure	
		2 at 10:00 a.m., LPN #1			alleged abuse of behaviors are		
	indicated there ha				acted on		
	_	arding Resident #C and			appropriately.Administrator or designee will review weekly the		
	two employees h	ad been terminated.			facility grievance log for		
	m 1: : 1	1 CD 11 1//C			completion of identified concer	ns	
		rd of Resident #C was			related to abuse and	_	
		0/12 at 2:00 p.m., and			behaviors.4. Results of these		
	indicated the resi	dent was admitted to the			reviews will be forwared to the		

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Facility ID: 000250

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155359	B. WIN			02/01/2012	
NAME OF I	PROVIDER OR SUPPLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FROVIDER OR SUFFLIE	R			INCHESTER RD		
RIVERBI	END HEALTH CAF	RE CENTER		FORT V	VAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)			
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG		DATE	
	· ·	11, with diagnoses which			facility risk management qualit assurance committee for revie	•	
		re not limited to,			and recommendations times 2		
	dementia and ar	ixiety.			months for 100% compliance.		
	The MDC (M:	imum Data Sat					
	The MDS (Min						
	· · · · · · · · · · · · · · · · · · ·	ated 1/17/12, indicated the					
		g and short tem memory					
	*	lifficulty making MDS indicated the					
	*	d limited assistance for					
		ensive assistance for					
	hygiene and toil	leting.					
	On 11/30/11 an	d 12/1/11, Nursing notes					
		#3 indicated the					
	following,	#3 marcated the					
	•	Resident #C was going					
	_	in her room and hit the					
		Nursing Assistant) when					
	`	ted. The note indicated the					
		ving "This is my house I					
	don't want you	-					
	1	an order was obtained					
	* '	oractitioner for Ativan 0.5					
	_	tramuscularly, as needed,					
	every six hours.						
		c (with) assistance from					
	-	ble to inject res (resident)					
	as ordered"	The to inject tes (testaent)					
		e resident was resting in					
		idicated "took a little over					
	_	es (resident) to quit hitting					
	` / *	cing c (with) w/c					
	(wheelchair) aft	er injection.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359			(X2) MULT A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/01/2012	
	PROVIDER OR SUPPLIE		S' 7	519 WI	IDDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	On 12/1/11 at 9 indicated the reshave two bruise measuring 3 cm cm. A facility incide indicated the CN had been caring night shift, were pending an inveverbal and phys An investigative taken from CNA LPN #3 hit resid An investigative from the LPN # report, between shift on 11/30/1 and CNA #2 ye statement indicate the resident yell holding her left the room" An investigative from the acting employed by the entering (Reside ask if we may pallegations of all	30 a.m., nursing notes sident was observed to so on her right forearm by 2 cm and 2 cm by 2 ent reporting form NA #2 and LPN #3, who for Resident #C on the suspended on 12/1/11, stigation of allegations of ical abuse. e statement, dated 12/1/11, A #2, indicated she saw					
	_	ne was mean and argued c) she "hit me"two					

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155359	B. WIN			02/01/2012	
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
DIVEDDE	END HEALTH CAR	E CENTER			INCHESTER RD VAYNE, IN 46819		
					VATINE, IIN 40019		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
1710		ed to right forearm"		1710	·	DATE	
		at reporting form,					
		ed both LPN #3 and CNA					
	#2 were terminate						
		y negative outcomes					
		are none. Family and MD					
		2011 of alligation (sic)					
	and bruises."	2011 Of alligation (SIC)					
	and bruises.						
	The Employee C	coaching Plan, for LPN					
		l, indicated the employee					
		or verbal and physical					
	abuse.	or verbar and physicar					
	aouse.						
	The Employee C	oaching Plan, dated					
		A #2, indicated the					
		rminated for failure to					
	report physical a						
	Toport physical a	ouse.					
	On 1/30/12 at 5:	00 p.m., the					
		as interviewed and					
		s not aware of the					
		e morning of 12/1/11.					
		or indicated LPN #4, who					
		ight nurses, reported the					
		een LPN #2 and Resident					
	#C to the day shi	Ift Nurses, on 12/1/11.					
	-	or indicated, LPN #3 and					
		spended, an investigation					
		statements were taken					
	from the individu						
		NA #2 did not report that					
		hit the resident until they					
		The Administrator					
	1 1	**					

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l l			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155359	B. WIN			02/01/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
RIVERRE	END HEALTH CAR	E CENTER			INCHESTER RD VAYNE, IN 46819		
					VATIVE, IIV 40019		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO T		ΓE	DATE
		ditional nurses (LPN #4					21112
		ceived disciplinary					
	warnings becaus	2 2					
		ervene when they heard					
	I	king place and because					
		ort the altercation					
		he administrator.					
	ininicalately to t	ne administrator.					
	A.2. The clinic:	al record of Resident #D					
		1/31/12 at 9:00 a.m., and					
		ident was admitted to the					
		10, was transferred to a					
	_	ital on 10/1/11, and was					
		e facility on 10/10/11,					
	with diagnosis w	•					
	Schizoaffective l						
	Semzouricetive	B1001 40 1.					
	On 11/14/11 at 4	:50 p.m., nuring notes					
		nt #D was yelling,					
		ving wreath off door and					
	_	chair across the hall.					
	A statement in a	n investigative report,					
		11/15/11, indicated CNA					
	•	ed because he made faces					
		ausing her "to become					
		g items in her room and					
	refusing medicat	_					
	~	so indicated CNA #6					
		Resident #D and poked					
	•	o be startled and agitated.					
		C					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		LDING	NSTRUCTION 00	(X3) DATE COMPI 02/01	ETED
	PROVIDER OR SUPPLIER		•	7519 W	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"I began work @ 11-14-2011(C down and hugger Resident (Reside very upset & (an began yelling & your hands off mame)Resident to her room" Tindicated Reside was lying about indicated CNA # her. The final incider undated, indicated investigation, the substantiated and terminated," The Coaching Plindicated CNA # because the empth distress to a residence on 1/31/12 at 10 Administrator increported the allegater on 11/15/11 and Administrator increported in the contraction in the coaching Plindicated CNA # because the empth distress to a residence on 1/31/12 at 10 Administrator increported the allegater on 11/15/11 and Administrator increported in the coaching Plindicated CNA # because the empth distress to a residence of 1/31/12 at 10 Administrator increported the allegater on 11/15/11 and 11	a by RN #16 indicated (at) 2:30 p on Monday NA #6's name) bent d (Resident #D). Int #D's name) became d) irritated. Resident then screaming saying "keep the (CNA #6's) then heads down the hall the statement further int #D thought RN #16 their medicine and 6 was making faces at a m					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 02/01	ETED
	PROVIDER OR SUPPLIER		•	7519 W	DDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	was immediately investigation was Administrator in	dicated the investigation #6's behavior had caused					
	records were revenue The employee rewas terminated of abuse, was review on 8/10/11. There was no document to the revenue abuse.	cord of CNA #6, who in 11/17/11 for mental wed. The CNA was hired					
	reviewed, includ CNAs #7 with a CNA #8 with a h CNA #9 with a hire d #11 with a hire d None of the CNA	hire date of 12/23/11, ire dated of 12/28/11, ire dated of 1/4/12, CNA ated of 1/4/12, and CNA					
	indicated there w #6's references h	as interviewed and ras no evidence that CNA					

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	OF CORRECTION OF CORRECTION 155359	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	recently hired employees references had been checked by the Unit Manager but the information had not been documented on the reference check forms used by the facility. The Administrator said the reference information was documented on notes that were in the Unit Manager's office. The Administrator indicated the Unit Manager should have documented the information on the facility's reference check forms and placed in the employees files. On 2/1/12 at 4:30 p.m., the Unit Manager brought in note with reference information for CNA #9, which included the person contacted and response, but did not include the date and time the person was contacted. The Abuse Prevention Program & (and) Policy, revised 11/11, provided by the Administrator was reviewed on 1/31/12, at 1:45 p.m. and indicated, "Screen all potential employees for a history of abuse, neglect, or mistreating residents/patients during the hiring	IAU		
	process. Screening will consist of, but not be limited to:Reference checks from previous and/or current employers "The facility prohibits the mistreatment, neglect, and abuse of residents/patients Report an incident immediately to the			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER: 155359	A. BUILDING B. WING	COMPLETED 02/01/2012
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE 7519 WINCHESTER RD FORT WAYNE, IN 46819	, ZIP CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE AS CROSS-REFERENCED T TAG DEFICIE	O THE APPROPRIATE NCY) (X5) COMPLETION COMPLETION DATE
	Administrator, and Director of Nursing Provide for the immediate safety of the resident/patient upon identification of suspected abuse		
	This Federal tag relates to Complaint IN00102878.		
	3.1-28(a)		

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Event ID: VFIP11

Facility ID: 000250

If continuation sheet Page 25 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155359	B. WIN			02/01/2	2012
			D. 17111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	S.			/INCHESTER RD		
RIVERBE	END HEALTH CAR	E CENTER			WAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX				COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
F0250		rovide medically-related					
SS=D		attain or maintain the					
		e physical, mental, and					
ļ		being of each resident.		50	l I F250 Care Plans for behavio	rc	02/21/2012
		ation, interview and	F02	30	and suicidal ideation1. Reside	_	02/21/2012
	· ·	ne facility failed to			identified with suicidal ideation		
		s with behavioral			have assessments completed,		
	interventions for	2 of 3 residents, who			care plans reviewed and revise	ed	
	were reviewed w	rith histories of suicidal			to include appropriate		
	ideation, in a san	nple of 5.			interventions. The DON and		
	(Resident #D and	d Resident #F)			facility will complete the initial	_	
		,			state State reportable (24 hour report) and the five day		
	Findings include				investigation per policy.2. The	,	
	r-manigs include.				DON or designee will complete		
	1 The alogad al	inical record of Resident			review of the nurse notes and		
					Social Service notes of resider		
		d on 1/31/12 at 9:00 a.m.,			identified with active diagnosis	of	
		e resident was admitted to			suicidal ideation or active symptoms of attempted harm	to	
	_	18/10, was transferred to			ensure that an appropriate	.0	
		pital on 10/1/11, after she			intervention to prevent harm is	in	
	cut her left wrist	and was readmitted to			place and on care plan. The		
	the facility on 10	0/10/11, with diagnosis			DON or designee will expand		
	which included S	Schizoaffective Disorder			chart review of nurses' notes a	ind	
	with suicidal tho	ughts and attempt.			Social service over the next		
		discharged from the			seven days to ensure 100% compliance.5 chart review have	۵,	
	facility on 11/18	C			been completed to determine	-	
	idenity on 11/10/				any other issues are identified		
	The model and re-	sirred a Daharrianal			related to abuse or self harm		
		eived a Behavioral			injuries. Two resident identifie		
	medicine evaluat				One resident was placed on e	very	
		ed the resident was			15 minute checks, until		
	ر ک	alta 60 mg twice daily and			Psychologist completes assessment and evaluation		
	"Follow-up with	Generations psychiatrist			2/2/12. Activity assessments a	_{ind}	
	d/ced (discontinu	ued) per family request."			care plan developed2/1/12. The care plan developed2/1/12.		
		_			resident was determined that I		
	Resident was rec	eiving cognitive			was not at risk currently to har		
		by with the last progress			himself and removed from eve	ry	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	, DDIG	00	COMPL	ETED
		155359		LDING		02/01/	2012
			B. WIN		A DODDEGG CHEV CHARE THE CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					/INCHESTER RD		
KIVEKBI	END HEALTH CAF	RE CENTER		FORT	WAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	note in the clini	cal record, dated 11/9/11.			15 minute checks. His risk pe		
	The note indica	ted the therapy was "to			Psychologist is transferring int	:0	
		riate coping skills with			community and living alone.	,	
	depressive episo				Specific behaviors to monitor	for	
	depressive episo	oues.			residents include: social isolation, verbalization of suici	dal	
					thoughts, feelings of being	uai	
					overwhelmed/anxiety-talking f	ast.	
	On 11/13/11 at	8:30 a.m., nursing notes			sweating, assure swallows	,	
	indicated Resid	ent #D was speaking of			medication. Specific		
	wanting to go w	vith her deceased			interventions to redirect and		
	boyfriend and w	vas trying to scratch			assist in calming this resident		
	-	e indicated the resident			include: encourage participati		
		one on one supervision and			in activities of his choice, educ	cate	
					family regarding OTC medications, staff should		
	•	tioner was notified.			continue to validate the reality	of	
		11:25 p.m., was started on			his pain, but also acknowledge		
	15 minute checl	KS.			that most pharmacologic optic		
	On 11/13/11 at	4:50 p.m., Resident #D			have been exhausted for pain		
	called 911 and	when the officers came to			management. Physician to		
	the facility. "she	e begged them to take her			consider Buspar because it is		
		she was evil and needed to			non-addictiive, reorient him av	vay	
	-	e note indicated the			from thinking a pill is going to		
					take away all discomfort, direct him that it is his responsibility		
		notified and a new order			cope with residual physical an		
		r Ativan 0.5 mg three			psychological discomforts, try		
	times daily for t	five days.			focus him on physical comfort		
					measures - warm towels,		
	On 11/14/11 at	4:30 p.m., social service			relaxation therapy, massage		
	notes indicated	Resident #D was			therapy.3. Facility administrate		
	discussing the d	lesire "to cleanse her			will re-educate Social Service		
	soul."				Director on policy and procedu		
		ted Resident #D entered			related to suicidal ideation and investigation related to abuse	, l	
					policy. DON or designee will		
		ce office and grabbed			re-educate staff on facility poli	cv	
	scissors and placed them to her neck.				related to reportable serious	- /	
	"writer interve	enedwr (writer) offered			incidents abuse policy, Behav	ior	
	validation for (I	Resident #D) regarding her			escalation and Crisis		
	feelings of wan	ting to join (deceased			Management, One-On-One		

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Facility ID: 000250

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETEI	D
		155359	B. WIN			02/01/201	2
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			INCHESTER RD		
RIVERBI	END HEALTH CAF	RE CENTER			VAYNE, IN 46819		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	MPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 *	ne)" The note indicated			Observation, and change in condition.IDT will review 24 ho		
	the hall nurse w	as notified of the event.			report and nurse notes of	oui	
					residents identified with active		
	On 11/14/11 at	5:00 p.m., the psychiatrist			diagnosis of suicidal ideation		
	was notified and	d an order was obtained to			during the clinical meeting to		
	administer Geo	don 10 mg intramuscularly			ensure appropriate interventio	ns	
		g intramuscularly as soon			are in place and care plans reflects appropriate intervention	une	
		to repeat in 12 hours.			and appropriate allegations of		
		1			abuse are reported timely and		
	On 11/15/11-11	/17/11, nursing notes			investigated appropriatley. Th	is	
	indicated the resident was calm and				will be monitored as an on-goi		
		5 minute checks.			process.4. Results of these C reviews will be forwared to the		
	Continued on 13	minute cheeks.			facility risk management quali	II	
	The questorly of	ocial services assessment,			assurance committee for revie		
					and recommendations times 2		
	1	indicated the care plan			months for 100% compliance.		
	_	wanderguard, smoking,					
	""	code status. There was no					
		are plan was updated with					
		address the resident's					
	suicidal ideation						
		1:00 p.m., the care plan					
	for Resident #D	was reviewed with the					
	Social Services	Director and no care plan					
	for suicidal idea	ation had been developed.					
	On 11/18/11 at	8:30 a.m., nursing notes					
		d to resident's room per					
		oise, writer entered					
		vith unit CNA, found					
) pleasant mood reports					
	dropped dish on floor. (Zero) behavior (sic) noted. Cont. (continue) with 15 min						
	(minute) checks						
	` ′						
	On 11/18/11 at	4:00 p.m., nursing notes					

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Facility ID: 000250

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		A. BUII	LDING	NSTRUCTION 00	(X3) DATE SU COMPLET 02/01/2	TED	
		199999	B. WIN			02/01/2	012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
RIVERBE	END HEALTH CAR	E CENTER			INCHESTER RD VAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		r notified (Psychiatrist's					
	· · · · · · · · · · · · · · · · · · ·	nt N.O. received to send					
	` •	ame) ER (emergency					
	· · · · · · · · · · · · · · · · · · ·	tx (evaluation and					
		er notified family. Charge					
		atient. 2nd charge nurse to					
	assess pt. (patier	nt)."					
	The Emergency	Transport report, dated					
	11/18/11, indica	ted Emergency Medical					
	Services were no	otified at 4:26 p.m.,					
		cility at 4:34 p.m., and left					
		the resident at 4:46 p.m.					
	1	nplaint indicated					
	"Hemorrhage/La	•					
	On 11/18/11 at 6	5:00 p.m., nursing notes					
		nd nurse called her and					
	said Resident #D	attempted to cut her					
		ndicated "Resident was at					
		here was a superficial cut					
		The CNA that was					
		the nurses station told me					
	_	O) had broken a bowl et					
	`	aid she thought she had					
	` ′	bol) all the pieces, but					
	`	ust have had a piece					
	,	[sic] stated that she was					
		saw (Resident #D) c					
		g in her hand going back					
	, ,	neck. The aid [sic] said					
	she had just ched						
	sile ilua just ellet	ANGU HOL					
	On 2/1/12 at 3:0	0 p.m., LPN #13, the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE C A. BUILDING B. WING	00	COM	e survey pleted 1/2012
	PROVIDER OR SUPPLIER		STREET 7519 \	ADDRESS, CITY, STATE, ZIP CO WINCHESTER RD WAYNE, IN 46819	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	nurse on duty on #D cut her neck, indicated she plather resident's necresident until the indicated the worbut when the resident when the resident when the resident when the edgopen. The nurse not bleeding. Resident #D had attempt on 10/1/1 thoughts on 11/1 to her neck and ethought on 11/14. There was no do arranged for the psychologist/11/14/11 inciden There was no downs developed on the resident's suidented 8/10 and B Policy, dated 9/1 on 2/1/12, were rand indicated, "The interdisciplidentify and man that are experient."	11/18/11 when Resident was interviewed. She ced a clean dressing on a k and remained with the EMS arrived. The nurse and appeared superficial ident tipped her head ges of the wound gapped indicated the wound was a history of a suicidal 11, voiced suicidal 13/11 and held a scissors expressed suicidal 11. cumentation the facility resident to be assessed by a psychiatrist, after the t. cumentation a care plan r implement to address eidal ideation. Inge in Condition Policy, ehavioral Management 1, provided by the DON reviewed at 2:45 p.m., inary team strives to age all residents/patient's cing a change in observation includes but				

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PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	Behavior Assess the resident/patient clinical status when a change of condition is identified Review careplan goals and intervention, modify as indicated"			
	2. On 2/1/12 at 10:00 a.m., the clinical record of Resident #F was reviewed and indicated the resident was admitted to the facility from a behavioral unit on 1/25/12 with diagnosis which included but were not limited to depressive disorder, chronic anxiety and chronic pain.			
	A psychiatric assessment from the hospital, dated 1/12/12, indicated the resident had "depression with suicidal thoughts."			
	The resident's care plan indicated the resident had multiple mental health issues including: depression with suicidal ideation; anxiety disorder, history of copied and benzodiazepine dependence; and personality disorder. The interventions included: Observe behaviors. Encourage resident to voice concerns. Encourage resident to participate in activities. Administer medications.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155359	B. WIN			02/01/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DI\/EDRE	END HEALTH CARI	ECENTER			INCHESTER RD VAYNE, IN 46819		
					VATINE, IIN 40019		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG			DATE
1710		ident statements made.		1710	·		DATE
	Follow up with r						
	consultation.	nentai neattii					
	If resident is rest	less impatient					
		uses resume conversation					
	task later.	uses resume conversation					
		or worsening signs and					
	symptoms and no						
		s and symptoms of					
	suicidal ideation						
	Suicidal ideation	•					
	The care plan did	d not have					
	•	alized interventions					
	_	ehaviors were to be					
		the resident was going to					
	· ·	voice concerns, what					
	_	oing to be encouraged to					
	_	chosocial well being,					
		angements for follow-up					
	-	sessments were to be					
		w the resident was going					
	_	to assure his safety.					
	to be supervised	to assure his surety.					
	The January 201	2 behavior monitoring					
	_	ne resident was being					
		rbal aggression and					
	refusal of care. T						
		uicidal ideation was					
	being monitored						
	oung momtored	•					
	On 2/1/12 at 11:0	00 a.m., Resident #F was					
		was observed sitting in					
		wheelchair with a tense					
	expression on his						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155359	A. BUILDING B. WING	00 	COMPLETED 02/01/2012
	ROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE VINCHESTER RD VAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	He indicated he was very anxious and needed more pain medication because he had pain in his back going down his leg. He felt like he was going to "explode." He liked bingo but was too upset to participate in any of the activities. The DON (Director of Nursing) was notified about the resident's concerns. On 2/1/12 at 4:15 p.m., Resident #F was interviewed. He was smiling and talking with staff. He indicated he had a shower and felt so much better. He talked to the nurse practitioner and she was arranging for him to have a pain consultation. 3.1-34(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DINI	10	00	COMPL	ETED
		155359	A. BUILDING	U		02/01/	2012
			B. WING	PDEET AL	DDDEGG GITY GTATE ZID GODE		
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
		E OENTED			NCHESTER RD		
KIVEKBE	END HEALTH CAR	E CENTER		ORIW	/AYNE, IN 46819		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
F0282	The services prov	vided or arranged by the					
SS=D		ovided by qualified persons					
		h each resident's written					
	plan of care.		1	- 1			
	Based on intervi	ew and record review, the	F0282		F282 Significant Medication E	rror,	02/21/2012
	facility failed to	follow physician orders			facility will follow physician orders1. Resident #B had		
	for the administr	ration of Procrit (a			physician's order clarified and		
	medication used	to stimulate the			dosage and proper follow through	uah	
	production of re	d blood cells). This			through on MD ordor for Procr		
	*	ted 1 of 1 residents			based off monthly lab results v		
	1	t in a sample of 5.			be followed. New order obtain	ied	
	_	t iii a sample of 5.			for Procrit to be given if		
	(Resident #B)				hemoglobin drops below 10.		
					D/C'd hematocrit order.2. Fac	•	
	Findings include	e			reviewed Pharmacy list of order Procrit to ensure administrater		
					per physicians orders.3.	cu	
	The clinical reco	ord of Resident #B was			Licensed staff will be re-educa	ited	
	reviewed on 1/3	0/12 at 11:00 a.m., and			on facility policy related to		
		sident was admitted to the			physician orders. Facility IDT	will	
		07 with diagnoses which			review new orders in the daily		
		re not limited to, chronic			clinical meeting to ensure		
		· ·			medication requiring lab	lor	
	kidney disease a	ind anemia.			monitoring is completed. DON designee will QA medications	ı Oi	
					requiring lab monitoring weekly	v to	
	The January 201	2, MAR (Medication			ensure labs have been comple		
	Administration 1	Record) for Resident #B			and medicationis administered		
	indicated Inject	1 ml. Procrit (20,000			per MD order.4. Results of the	ese	
	units) every 2 w	eeks "keep HBG			QA reviews will be forwared to		
	10/3.3"(sic).				facility risk management qualit		
	10/3.3 (510).				assurance committee for revie		
	Dhygiaian and	doted 0/0/11 indicated			and recommendations times 2		
		s, dated 9/9/11, indicated			months for 100% compliance.		
		to be held if the resident's					
	_	greater than 10 and or					
	the hematocrit w	vas greater than 33. These					
	parameters were	not on the January 2012					
	MAR.	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VFIP11

Facility ID: 000250

If continuation sheet Page 34 of 49

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155359	B. WING		02/01/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				VINCHESTER RD	
	END HEALTH CAR	E CENTER		WAYNE, IN 46819	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		, dated 10/8/11, indicated	TAG		DATE
	•	(Complete Blood Count)			
		tinued and the CBC was			
	to be done month				
		to be given/held twice			
		n the Hemoglobin and			
	I	s but the facility was only			
		noglobin and hematocrit			
	levels monthly.	nogroom una nomatoorit			
	The CBC, dated	11/1/11, indicated the			
		globin was 10 and the			
	·	30 and as a result, the			
	Procrit should ha	, , , , , , , , , , , , , , , , , , ,			
		signed as given 11/1/11			
		ut with error written			
	above the entry a	and there was no other			
		ne Procrit was given			
	during the month	of November 2011.			
	The CBCs done	in December 2011 and			
	January 2012 inc	licated the hemoglobin			
	and hematocrits	were greater than 10 and			
	33 respectively d	luring both months and as			
	a result the Procr	rit was not to be given.			
		30 p.m., the DON			
	`	sing) indicated there was			
	confusion with the	ne Procrit order and the			
	physician had cla	arified the order.			
	Physician's order				
		20,000 units was to be			
	l *	neous one time monthly			
	after CBC results	s to keep the hemoglobin			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	LAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COL			X3) DATE SURVEY COMPLETED 02/01/2012	
	PROVIDER OR SUPPLIE		7519 W	ADDRESS, CITY, STATE, ZIP CODE VINCHESTER RD WAYNE, IN 46819	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	· ·	R LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA	IIE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VFIP11

Facility ID: 000250

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			RVEY		
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDI		BUILDING 00 COMPL		COMPLETE	ED	
		155359	B. WIN			02/01/20 ⁻	12
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/INCHESTER RD		
RIVERBE	END HEALTH CARE	ECENTER			WAYNE, IN 46819		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B. CROSS-REFERENCED TO THE APPROPR		CC CC	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	•	nsure that the resident					
SS=D		ins as free of accident					
	•	sible; and each resident					
	receives adequate	s to prevent accidents.					
l		ew and record review, the	F03	23	F323 Supervision of behaviors	s. 0	2/21/2012
		provide increased	103	23	psycholgical needs1. Residen		2/21/2012
					#D is no longer at the facility.		
		n a resident expressed			She was transferred to psychia	atric	
		and had been observed			hospital. Social Service was suspended pending investigati	on	
	•	issors and place them to			for not following Policy and	On	
	,	f 3 residents reviewed			Procedure and improperly		
		suicidal ideation in a			communicating behavior crisis		
	sample of 5.				management interventions.2.		
	(Resident #D)				Residents who exhibit mental	or	
	Findings include	:			psychosocial issues will be interviewed by Social Service staff and referred for appropria treatment with outside services		
	The closed clinic	al record of Resident #D			needs arise.3. Residents who		
	was reviewed on	1/31/12 at 9:00 a.m., and			display violent/antisocial		
		dent was admitted to the			behaviors will be reviewed		
	facility on 6/18/1	0, was transferred to a			immediately by reporting to the facility administrator and or DC		
	-	tal on 10/1/11, after she			for discussion for outside		
		and was readmitted to			psychological		
		/10/11, with diagnosis			assessemnts/interventions.		
	_	Schizoaffective Disorder			These residents will be review		
		ughts and attempt.			and monitored in the facility da clinical meeting as issues arise	-	
		•			and determination made by ca		
		discharged from the			giving team as to appropriate		
	facility on 11/18/	11.			interventions to meet resident		
	mi .				psychosocial needs. Staff was	;	
		eived a Behavioral			re-educated on notification of Administrator and DON need t	_	
	medicine evaluat				be called 24/7DON or design		
		ed the resident was			will randomly QA two charts		
	receiving Cymba	lta 60 mg twice daily and			weekly for 2 months of residen	ts	
	"Follow-up with	Generations psychiatrist			with known behavioral issues t	ю	
	d/ced (discontinu	ied) per family request."			determine that facility is meetir	ng	

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Event ID: VFIP11

Facility ID: 000250

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155359	B. WIN			02/01/2012	
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	C		7519 W	INCHESTER RD		
RIVERBI	END HEALTH CAR	E CENTER		FORT V	VAYNE, IN 46819		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ON
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	_	TAG	,	DATE	
TAG	Resident was red behavioral thera note in the clinic The note indicate increase appropriate depressive episor On 11/13/11 at 8 indicated Reside wanting to go with boyfriend and with the facility, "she to jail because sligo to jail" The physician was now was obtained for times daily for fill on 11/14/11 at 4 notes indicated I	8:30 a.m., nursing notes ent #D was speaking of ith her deceased as trying to scratch e indicated the resident me on one supervision and itoner was notified. 11:25 p.m., was started on its. 1:50 p.m., Resident #D when the officers came to begged them to take her me was evil and needed to note indicated the offied and a new order Ativan 0.5 mg three itve days. 1:30 p.m., social service		TAG	psycho social needs of said residents until 100% compliance.4. Results of thes QA reviews will be forwared to facility risk management quality assurance committee for review and recommendations times 2 months for 100% compliance.	e the y	
		ed Resident #D entered					
		e office and grabbed					
		ced them to her neck.					ļ
	_	nedwr (writer) offered					

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Event ID: VFIP11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 02/01/	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	l			DDRESS, CITY, STATE, ZIP CODE		
RIVERBI	END HEALTH CAR	E CENTER			NCHESTER RD /AYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	feelings of want boyfriend's name	desident #D) regarding her ing to join (deceased e)" The note indicated as notified of the event.					
	was notified and administer Geod and Ativan 1 mg	5:00 p.m., the psychiatrist an order was obtained to lon 10 mg intramuscularly g intramuscularly as soon to repeat in 12 hours.					
		/17/11, nursing notes ident was calm and minute checks.					
	dated 11/16/11, was updated for aggression and continuous indication the calculation interventions to suicidal ideation supervision. On 1/31/12, at 1 for Resident #D Social Services 1	cial services assessment, indicated the care plan wanderguard, smoking, code status. There was no are plan was updated with address the resident's or need for increased :00 p.m., the care plan was reviewed with the Director and no care plan tion had been developed.					
	indicated "called staff report of no resident room w resident c (with)	3:30 a.m., nursing notes I to resident's room per bise, writer entered ith unit CNA, found pleasant mood reports floor. (Zero) behavior					

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Event ID: VFIP11

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CON A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER	7519 WII	DDRESS, CITY, STATE, ZIP CODE NCHESTER RD 'AYNE, IN 46819	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
(sic) noted. Cont. (continue) with 15 min (minute) checks." On 11/18/11 at 4:00 p.m., nursing notes indicated "Writer notified (Psychiatrist's Name) of incident N.O. received to send to (Hospital's Name) ER (emergency room) for eval & tx (evaluation and treatment). Writer notified family. Charge nurse c (with) patient. 2nd charge nurse to assess pt. (patient)." The Emergency Transport report, dated 11/18/11, indicated Emergency Medical Services were notified at 4:26 p.m., arrived at the facility at 4:34 p.m., and left the facility with the resident at 4:46 p.m. The dispatch complaint indicated "Hemorrhage/Laceration." On 11/18/11 at 6:00 p.m., nursing notes indicated a second nurse called her and said Resident #D attempted to cut her neck. The note indicated "Resident was at nurses station. There was a superficial cut from ear to ear. The CNA that was watching her at the nurses station told me that (Resident #D) had broken a bowl et (and) the CNA said she thought she had cleaned (up symbol) all the pieces, but (Resident #D) must have had a piece hidden. The aid [sic] stated that she was walking et (and) saw (Resident #D) c (with) something in her hand going back and forth on her neck. The aid [sic] said			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	she had just checked her" On 2/1/12 at 3:00 p.m., LPN #13, the nurse on duty on 11/18/11 when Resident #D cut her neck, was interviewed. She indicated she placed a clean dressing on the resident's neck and remained with the resident until the EMS arrived. The nurse indicated the wound appeared superficial but when the resident tipped her head backward the edges of the wound gapped open. The nurse indicated the wound was not bleeding. Resident #D had a history of a suicidal attempt on 10/1/11, voiced suicidal thoughts on 11/13/11 and held a scissors to her neck and expressed suicidal thought on 11/14/11. Other than the ongoing 15 minute checks, there was no documentation the resident was provided increased supervision after the 11/14/11 incident. The Clinical Change in Condition Policy, dated 8/10 and Behavioral Management Policy, dated 9/11, provided by the DON on 2/1/12, were reviewed at 2:45 p.m., and indicated, "The interdisciplinary team strives to identify and manage all residents/patient's that are experiencing a change in			
	and indicated, "The interdisciplinary team strives to identify and manage all residents/patient's			

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PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155359	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE VINCHESTER RD WAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	is not limited to changes in:Behavior" "One-on-One Observation may be implemented when a resident/patient exhibits the following behavior that may include but is not limited to: Suicidal verbalizations" 3.1-45(a)(2)			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER		STREET 2 7519 W	ADDRESS, CITY, STATE, ZIP CODE /INCHESTER RD WAYNE, IN 46819	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	The facility must el Infection Control Forovide a safe, sa environment and the development and and infection. (a) Infection Control Forogram Long Control Program Long Control P	establish and maintain an Program designed to nitary and comfortable o help prevent the transmission of disease of Program establish an Infection under which it - controls, and prevents cility; procedures, such as a applied to an individual ecord of incidents and related to infections. The add of Infection ection Control Program resident needs isolation to do finfection, the facility esident. It prohibit employees with disease or infected skin at contact with residents or contact will transmit the est require staff to wash each direct resident contact ishing is indicated by	IAG	DEI CLEACT)	DATE
	transport linens so of infection. Based on observe record review, the staff were washing	ation, interview and see facility failed to assure and their hands after the gloves. This deficiency	F0441	F441 Preventing the spread o infection-washing hands after removing gloves1. Residents who identified will be reassess for signs and symptoms of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155359	B. WIN			02/01/2012
		l.		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	t .			INCHESTER RD	
RIVERBE	END HEALTH CAR	E CENTER			VAYNE, IN 46819	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	affected two of t	wo staff persons			infection related to allegation	
	observed for han	dwashing during care of			ofgloves worn and hand washi not completed appropriately.	ng
	Resident G.				Staff that were observed by	
	(RN #14 and CN	(A #15)			surveyor not following hand	
		,			washing policy and or gloves	
	Findings include	:			worn multiple resident care wil	
					have coaching plans complete	d
	On 1/31/12 betw	een 5:45 a.m. and 6:15			and re-education and skills observation check off	
		ervation care for Resident			completed.2. A review of	
	#G, the following				residents for signs and sympto	oms
	#G, the following	g was observed.			of infection will be reviewed tin	nes
	CD I A //1.5 1	1.0 .1			72 hours for any indication of	
		d Resident #G's peri-area.			infection control issues will be	
		the resident to the left			addressed immediately.3. Fac	-
		the resident's buttocks			staff re-educated on policy and procedure related to hand	,
		he resident to the right			washing completed with a visu	ıal
	side. Resident #0	G was soiled with stool			skills check off. DON or design	
	and additional lin	nens were needed.			will conduct daily random visua	al
	CNA #15 remov	ed her gloves and exited			observation of staff related to	
	the room withou	t first washing or			care to ensure that hand wash is completed appropriately.	ing
	sanitizing her ha	nds to retrieve linen from			Immediate re-education will be	,
	the linen cart.				completed for identified	
	CNA #15 returne	ed to the room, donned			concerns.4. Results of these (
		ned washing the resident,			reviews will be forwared to the	
	_	surface and positioned the			facility risk management qualit assurance committee for revie	•
		IA bagged up the soiled			and recommendations times 2	
		er gloves, and left the			months for 100% compliance.	
		st washing her hands.			•	
	100m without m	or washing her hands.				
	 RN #14 was assi	sting with Resident #G's				
		aned gloves assisted in				
		ent, and placed the				
	_	•				
		e bag on the bed. RN #15				
	1	ves and left the room to				
	retrieve linens w	ithout first washing her				

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	OF CORRECTION IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/01/2012
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	hands. RN #14 reentered the room, donned gloves, removed a soiled dressing on Resident G's buttocks and reapplied a clean dressing that she had brought in when she entered the room, emptied the wash basin, removed her gloves and left the room without first sanitizing or washing her hands. RN #14 returned to the room with an ointment, donned gloves, and applied the ointment to the resident's arms and legs. RN #14 removed her gloves and left the room without first washing her hands. On 1/31/12 at 2:30 p.m., the DON (Director of Nursing) was interviewed and indicated staff were to wash their hands after providing care. The handwashing policy, dated 2/09, provided by the Administrator, was reviewed on 1/31/12 at 9:00 a.m., and indicated, "Handwashing is mandated between resident/patient contact in an effort to prevent the spread of infection. Hands must be washed after the following, removal of gloves. 3.1-18(1)			

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PRINTED: 02/23/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155359	A. BUILDING B. WING	00	COMI 02/0	PLETED 1/2012
	ROVIDER OR SUPPLIER		7519 W	ADDRESS, CITY, STATE, ZIP CO INCHESTER RD WAYNE, IN 46819	DE	
RIVERBE (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155359	B. WIN			02/01/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				INCHESTER RD		
RIVERBE	END HEALTH CARE	E CENTER			VAYNE, IN 46819		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F9999	3.1-13 ADMINISMANAGEMENT (g) The administration shall not function supervisor, for expursing or food state same hours. This state rule was by: Based on intervier facility failed to a Department of Hinjury which results.	STRATION AND Trator is responsible for gement of the facility but as a departmental example, director of service supervisor, during The responsibility of the all include, but are not	F99	TAG	(EACH CORRECTIVE ACTION SHOULD BE	g The ble all cal ents	
	Findings including	ng:					
	The clinical reco	rd of Resident #D was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				nstruction 00	(X3) DATE COMPL		
		155359	B. WIN	LDING IG		02/01/	/2012
	PROVIDER OR SUPPLIE		•	7519 W	ADDRESS, CITY, STATE, ZIP CODE INCHESTER RD VAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	reviewed on 1/3 indicated the rest facility on 6/18/psychiatric hospicut her left wrist the facility on 10 which included with suicidal the On 11/18/11 at 4 indicated the psy an incident and sent to the emergand treatment. The Emergency 11/18/11, indicated the facility with The dispatch con "Hemorrhage/Later On 11/18/11 at 60 on 11/1	1/12 at 9:00 a.m., and sident was admitted to the 10, was transferred to a sital on 10/1/11, after she and was readmitted to 0/10/11, with diagnosis Schizoaffective Disorder bughts and attempt. 4:00 p.m., nursing notes ychiatrist was notified of ordered the resident be gency room for evaluation Transport report, dated ted Emergency Medical otified at 4:26 p.m., cility at 4:34 p.m., and left the resident at 4:46 p.m. mplaint indicated		TAG			DATE
	neck. The note in nurses station. The from ear to ear. watching her at that (Resident #1 (and) the CNA states.)	O attempted to cut her ndicated "Resident was at There was a superficial cut The CNA that was the nurses station told me D) had broken a bowl et said she thought she had					
	neck. The note in nurses station. The from ear to ear. watching her at that (Resident #1 (and) the CNA states.)	The CNA that was the nurses station told me D) had broken a bowl et					

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	of Correction identification number: 155359	A. BUILDING B. WING	00 	COMPI 02/01	
	PROVIDER OR SUPPLIER END HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	(Resident #D) must have had a piece hidden. The aid [sic] stated that she was walking et (and) saw (Resident #D) c (with) something in her hand going back and forth on her neck. The aid [sic] said she had just checked her" On 1/31/12, at 2:30 p.m., the Administrator indicated the incident had not been reported to the ISDH. On 2/1/12 at 3:00 p.m., LPN #13, the nurse on duty on 11/18/11 when Resident #D cut her neck, was interviewed. She indicated she placed a clean dressing on the resident's neck and remained with the resident until the EMS arrived. The nurse indicated the wound appeared superficial but when the resident tipped her head backward the edges of the wound gapped open. The nurse indicated the wound was not bleeding. 3.1-13(g)(1)				

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